Topics in Primary Care Medicine

Health Issues of Homeless Persons

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"Topics in Primary Care Medicine" presents articles on common diagnostic or therapeutic problems encountered in primary care practice. Physicians interested in contributing to the series are encouraged to contact the series' editors.

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Homelessness implies not only a lack of shelter, but also a degree of social isolation. Homelessness is essentially a socioeconomic problem; the homeless also have a high prevalence of medical and mental health problems and frequently use public emergency departments. We review the demographics and causes of homelessness and the diseases that homeless people are commonly afflicted with and discuss strategies to manage their problems.

Demographics and Causes

Although the homeless population has always been more diverse than such stereotypes as the alcoholic men who frequented the flophouses and missions of skid row, the ranks of the homeless have been swelled recently by women, families, youth, seniors, disabled persons, veterans, and people with the acquired immunodeficiency syndrome (AIDS) or AIDS-related conditions (ARC). Estimates of the number of homeless nationwide range from 350,000 to 3 million. In San Francisco, there are about 5,000 to 6,000 homeless people on any given night. Available data and anecdotal evidence suggest some general characteristics. The average age is about 37 years. Most are men, although women constitute about 20%. Ethnic minorities, particularly blacks, Latinos, and Native Americans, are overrepresented, together composing about half of the homeless population. Between 20% and 40% of the homeless have some education beyond high school.

The factors contributing to homelessness can be as diverse as the populations affected. Many are homeless due to the combined forces of economic setback, a lack of affordable housing, and the failure of the "social safety net." In this group are the physically disabled or chronically ill, the elderly on fixed inadequate incomes, or able-bodied single adults receiving General Assistance who often find it impossible to maintain stable housing on their limited monthly grant. Many of the new homeless have experienced severe disruptions in their lives, such as women who have fled abusive partners, homeless youth who often have also left abusive home situations, the 30% to 40% who are veterans—half from the Vietnam era—or people with AIDS or ARC.

Finally, there is a group of people whose homelessness is often linked to a chronic condition, such as alcoholism or mental illness. Deinstitutionalization and inadequate community mental health programs have left many to fend for themselves on the streets. This group generally receives the most attention, primarily because alcoholism and mental illness are caught up in the polemics over the causes of homelessness and because they are very visible on the city streets. Neither condition by itself, however, is an explanation for homelessness, and the daily uncertainties related to food, shelter, and security dramatically diminish the possibilities of recovery.

Health Problems

Living on the streets exposes people to extremes in temperature. They are often not protected from rain or snow. Their clothes, particularly their shoes, may be ill fitting. Access to showers and clean clothes is restricted. Sleeping arrangements are often bizarre. All of one's possessions must be carried, and shelters and dining rooms are usually crowded so that lining up for hours is a standard part of one's day. Health problems are exacerbated by the street life. Homeless persons often come late to medical attention and are less likely to return for follow-up visits. The homeless have a high prevalence of physical and mental illnesses and are frequent users of emergency departments. They are often admitted for far-advanced conditions that could have been prevented or treated earlier as outpatients.

Foot Problems and Cellulitis

Foot problems are common because the homeless spend many hours standing in lines or walking. Secondhand, worn thin, or ill-fitting shoes cause calluses or abrasions. Fungal foot infections are common. The inability to lie down leads to edema and venous stasis that, when combined with insect bites or abrasions, may lead to ulceration and cellulitis. Hospital admissions for the treatment of cellulitis or deep ulceration are common. In a chart review, it was found that two thirds of homeless persons presenting with lacerations came to medical attention more than 24 hours after the injury, and

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less than 30% returned for follow-up wound care. When follow-up is doubtful, adhesive wound closure, such as Steristrip, preceded by copious irrigation, may lead to fewer wound complications than when sutures are left in too long. Medicated bandages, such as Unna's boots, may be used to facilitate the healing of leg ulcers and may be left on for a week rather than prescribing daily wet to dry dressing changes. A solution of one part bleach to ten parts water applied to bathroom floors and shower stalls in shelters can inexpensively and effectively kill common fungi that can cause foot infections. Heavy-duty nail clippers need to be available to cut overgrown, thickened nails.

Upper Respiratory Tract Infections

Common colds and other respiratory tract infections spread easily in overcrowded shelters and food lines. The inability to rest and the high rate of smoking exacerbate the severity of these diseases. Annual influenza vaccination should be offered to all homeless persons because of the ease of spread and their inability to rest and recuperate in the shelters or on the street. Smoking cessation should be recommended just as it should to the general public.

Tuberculosis

The prevalence of tuberculosis is greatly increased among the homeless. The rate varies from epidemic proportions in New York to lower rates in other cities. Boston has had an outbreak of isoniazid- and streptomycin-resistant cases. Tuberculosis is an important problem among the homeless and shelter staff. Thorough contact investigation is important and effective when a case is detected because crowded conditions facilitate infection transmission. Compliance with random screening with purified-protein-derivative skin tests is poor but should be done to offer prophylaxis to this high-risk, relatively young group. In cases of possible tuberculosis, sputum specimen collection and chest x-ray films should be done on site, and the acid-fast bacilli smear and chest x-ray film should be reviewed before the person leaves the site. Once a case of current tuberculosis is diagnosed, the treatment should be supervised daily with the aid of the city or county tuberculosis control program, and the person should be moved into a single-room residence. The use of a four-drug, six-month regimen is more likely to be completed than longer regimens. Shelter staff need to be educated about tuberculosis and screened for infection. Adequate ventilation, less crowding, and ultraviolet lights should be helpful in reducing disease transmission in the shelters.

Infestations

Body and head lice and scabies are frequent problems. Treatment is difficult because of reexposure in the shelters and a lack of facilities to shower and wash one's clothes. Insect bites may lead to local abscesses, impetigo, cellulitis, and occasionally septicemia. Local and systemic toxic reactions, including seizures, may occur in persons who have been treated repeatedly and for prolonged periods with lindane. Lindane lotion is the treatment of choice for scabies. For head lice, a pyrethrin or lindane shampoo can be used. Careful combing with a stiff, fine-toothed comb will remove residual nits. Body lice can be treated by simply washing with soap and water and hot water washing of clothes and bedding. When infestation is extensive, lindane shampoo to the entire body excluding the eyes and mucous membranes will improve the outcome. Dispensing a pediculocide to a person who does not have a change of clothes or access to shower facilities is likely to be futile. The health care provider needs to know where those resources can be found or provide them on site.

Hypothermia

Persons living on the streets are at an increased risk for hypothermia, particularly if their consciousness is impaired (from alcohol or drugs), if they are lying on concrete or other surfaces that conduct body heat away rapidly, or are wet from the weather or incontinence. Temperatures do not have to be below freezing to cause hypothermia.

Substance Abuse

Most of the data on the prevalence of alcohol and drug abuse is from studies of male shelter users in skid row areas, and the rate is high. Detoxification and 28-day programs provide islands of sobriety, but usually the person is deposited back on the streets homeless and jobless with little likelihood of remaining sober. Longer term programs that deal with the other social and economic problems do better. All drug abusers need to be taught AIDS and other infection risk reduction. For those unwilling to stop intravenous drug abuse, small bottles of household bleach with instructions on how to clean their "rig" can be provided and may reduce the risk of infection. The use of condoms needs to be promoted and condoms provided. As the AIDS epidemic increasingly affects intravenous drug abusers, the number of persons with AIDS or ARC who are living on the streets is expected to grow.

Mental Health

Large numbers of mentally ill persons live on the streets and in shelters. They are often visible, leading to the stereotypic perception that most homeless persons are mentally ill. Data suggest that the incidence of significant mental health problems among the homeless is in the 30% to 40% range. Among the homeless mentally ill, women are overrepresented. Concurrent physical health problems are reported by half to a third of the homeless mentally ill. The mentally ill are often robbed or assaulted because they are among the easiest prey. The sickest of the mentally ill are the least likely to seek mental health care and are likely to end up in involuntary incarceration.

Deinstitutionalization of the mentally ill in the 1960s and 1970s shifted the focus of treatment from the hospital to the community, but community-based housing and care were never adequately developed. The streets became the repositories for many of those who were least able to care for themselves. Treatment of the homeless mentally ill is complex, often depending on resources that are not particularly tailored to the population. It is clear, for example, that traditional mental health services must be supplemented by affordable housing with on-site social support to enable people to live at the highest level of independence possible. In addition, a system of case management can coordinate mental health, entitlements, housing, transportation, and other services that are critical to the overall functioning of clients. The appropriate use of outpatient treatment and other mental health services can only be realized when other needs for security and support are taken care of.

Trauma

Trauma is a significant cause of morbidity and mortality among the homeless. Homeless women are at an increased risk of sexual assault.

Other Chronic Diseases

Hypertension, diabetes mellitus, and chronic obstructive pulmonary disease probably occur no more frequently than in the general population. Optimal control of these problems is made difficult if not impossible by the lack of stable housing, the inability to select one's diet, and difficulties in storing and taking medication on schedule. Treating diabetes is particularly difficult because the time and composition of meals is not under a homeless person's control. Insulin syringes have a high street value, and diabetic persons are often targeted for robbery. The temptation to sell the syringes is also high.

Populations With Special Needs

Youth. Homeless and runaway youth can no longer rely on their families for financial and emotional support, and they are ineligible for many entitlements programs. Some turn to "hustling" (prostitution) to get by, placing them at high risk for sexually transmitted diseases. Suicidal ideation and histories of suicide attempts are common. Active outreach programs that offer condoms and bleach, nonjudgmental counseling, meal vouchers, and a place to stay can be a first step in getting homeless youth off the streets.

Families. Homeless families are commonly headed by women. Some have a long history of residential instability, while others have only recently lost their housing. The mothers in many cases have fled abusive partners, have poor job skills, and lack supportive relationships. The children of homeless families are usually below grade level in school and often suffer from learning disabilities and depression. Nutrition is frequently inadequate. Successful programs must combine counseling and rehabilitative services with stable income and housing.

Barriers to Health Care

Homeless people face a variety of barriers to health care. Health services available to the homeless are limited, and homeless people may find it difficult to identify the appropriate place of care. Public clinics and public hospital emergency departments may be geographically distant and transportation unaffordable. Long waits can sometimes mean that a meal or a shelter bed is lost. Complicated registration processes and even minimal patient fees present further sources of discouragement. The lack of a sensitive and sympathetic staff, or the inability of a single service site to address the wide range of problems experienced by homeless people, can pose additional barriers.

In some cases, health care problems are denied or are given a low priority by homeless persons. A lack of understanding of their health needs, the fear of losing control over their daily life and possessions, self-destructive behavior, embarrassment about their personal hygiene or clothing, and the need to attend to other survival needs may cause them to come to medical attention only when their disease is far advanced. Many homeless have had dissatisfying experiences with the health care system in the past and are skeptical that going again will do any good. For some, life on the streets has led to a general skepticism about institutions.

Primary Care Providers and the Homeless

Providers must first be nonjudgmental and establish confidence and mutual trust. Existing medical, mental health, and social work services must be actively coordinated. A forgiving schedule and allowing drop-in visits are essential for accommodating the vagaries of street life, although keeping appointments might become part of a rehabilitative regimen. Early intervention and continuity of care are best accomplished through ready availability, active outreach, and persistent follow-up. Working with homeless people can frequently be labor-intensive and frustrating. It involves advocacy for entitlements, housing, employment, and needed health care services as integral components of a therapeutic intervention. Experienced staff sensitive to the needs of homeless people must work with hospital discharge planners and other health care providers to ensure that care is given in a manner that is appropriate to the life circumstances of homeless people.

Conclusions

The homeless in America are a large, diverse, and growing group who have special health and social service needs. Although it is important to avoid the short-sightedness of institutionalizing homelessness, there is nevertheless justification for developing services that specifically target homeless people as part of the overall strategy for confronting homelessness and its consequences. Those services must be tailored to the actual life conditions of homeless people, they must acknowledge that medical problems are part of a much broader set of circumstances, and they must be provided in a sensitive and committed manner.

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